DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	C 02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	This Plan of Correction constitutes our written allegation of compliance. "This Plan of Correction is submitted as required under federal and state regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that scope or severity regarding any of the deficiencies cited are correctly applied." **F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** To address the situation involving the failure of CNA #2 to immediately report to the Administrator or designee allegations of abuse for residents #9 and #12, the facility took the action following. On 1/25/12 (immediately after being notified of the untimely reporting) CNA #2 was thoroughly re-educated on our Abuse/Neglect policy, the Elder Justice Act, and the associated reporting	3/17/12 3/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer B. Henderson — TITLE: Executive Director — (X6) DATE: 2/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, review of facility policy, observation and interview, the facility failed to immediately report to the Administrator allegations of abuse for two residents (#9 and #12) of twelve residents reviewed. The findings included: Resident #9 was admitted to the facility on December 28, 2005, with diagnoses including Constipation, Atrial Fibrillation, Gastrointestinal Reflux Disease, Chronic Obstructive Pulmonary Disease, Acute Renal Failure, Sepsis, Diabetes Mellitus, Hypertension, Myelodysplastic Syndrome (group of bone marrow stem cell disorders), Pancytopenia (reduction in the number of red and white blood cells and platelets), History of Gastrointestinal Bleed, Osteoporosis, Chronic Pain, Coronary Artery Disease and History of Gastric Ulcer. Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident scored 15 of 15 on the BIMS (Brief Interview for Mental Status) with no impairment of decision-making skills and required extensive to total assistance with activities of daily living (ADLs). Medical record review of the physician's recapitulation orders dated January 1-31, 2012, revealed the resident received Morphine Sulfate 60 mg (milligrams) twice daily for pain.	F 225	obligations for both. CNA #2 also received a disciplinary action for failing to immediately report suspected abuse/neglect since documentation showed that she had previously been educated on the Abuse/Neglect policy and associated reporting obligations on both 11/22/11 and on 1/13/12. CNA #2 also was re-educated on our Abuse/Neglect policy and reporting obligations on 2/3/12 at one of our regular Abuse/Neglect and reporting obligations inservices. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. Training, systemic changes, audits, and a performance improvement program as described below have been implemented to ensure that all allegations/suspicions of abuse/neglect are reported to the Administrator or designee immediately so that no resident is ever affected by this. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 1/25/12 Department Heads interviewed all alert and oriented residents that had not	3/17/12

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F 225	Continued From page 2 Review of a facility investigation dated January 18, 2012, related to allegations of abuse by Certified Nursing Assistant (CNA #1) on January 11, 2012, revealed resident #9 reported a "...goes too fast and is consequently a little rough because (resident #9) is generally pretty sore and needs someone to go slow with (resident)...also feels that (CNA #1) goes too fast to clean...good when changing...needs to go slower and use the pad to help position...didn't think (CNA #1) was intentionally trying to be rough...or hurt (resident)." Review of a written statement by CNA #2 dated January 12, 2012, (which was part of the facility's investigation) revealed, "...(CNA #1) doesn't get the residents cleaned enough and...gets irritated when a resident asked to go to the bathroom and...tells them to get in there...rough with the residents when changing them and (repositioning) them in bed. I'm talking about rolling them and pulling them up in bed and raising (their) head to tuck the pillow under...head." Review of the facility's policy for abuse revealed, "...All allegations of abuse are reported immediately to the Executive Director (Administrator) or designated representative...All associates will report suspected abuse to the Executive Director and/or immediate supervisor..." Observation on January 25, 2012, at 11:50 a.m., revealed resident #9 lying in bed. Interview in the resident's room revealed the resident had Osteoarthritis and "turning me hurts. The nurse tells them to use the pad when moving me."	F 225	previously been interviewed for this investigation—as determined by the 802 and asked them if they had ever been treated roughly by staff, if any staff member has ever yelled at or been rude to them, and if they had ever felt afraid due to the way either themselves or another resident was treated. None of the residents stated that they had experienced any problems of this nature. On 1/25/12—1/27/12 associates were interviewed and asked if they had every witnessed any staff member mistreat any resident(s). None of the associates stated that they had ever witnessed any situation like this. On 2/3/12 the SDC trained staff on all shifts on the topic of Abuse/Neglect and reporting obligations. Associates receive this training upon orientation and at a minimum of 4 times per year. Social Services/ED/DON or designee will additionally perform interviews with both associates and residents to ensure no allegation/suspicion of abuse/neglect goes unreported and that all allegations/suspicions of this nature are immediately reported. **How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place?**	3/17/12

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F 225	Continued From page 3 Interview on January 25, 2012, at 2:25 p.m., in the conference room, with CNA #2 confirmed the CNA's written statement noted above. Continued interview confirmed CNA #2 had witnessed CNA #1 be rough with residents prior to January 11, 2012. CNA #2 stated, "It kind of scared me when (CNA #1) would get irritated with residents...felt like...would get irritated with me too." Continued interview confirmed CNA #2 witnessed CNA #1 "push" the neck pillow under resident #9's head in a rough manner. Continued interview with CNA #2 confirmed the CNA interpreted the actions of CNA #1 as intentional abuse of the resident. Continued interview confirmed CNA #2 did not report the allegations prior to January 11, 2012, to the CNA's immediate supervisor or administrative staff. The CNA stated, "I didn't think about it at the time." Continued interview with CNA #2 on January 25, 2012, at 2:25 p.m., in the conference room revealed CNA #2 witnessed resident #12 with the call light on. CNA #1 and CNA #2 entered the resident's room. Resident #12 reported the need to go to the bathroom. Continued interview with CNA #2 revealed CNA #1 told the resident in a harsh manner, "Get in there!" Continued interview confirmed the CNA interpreted the actions of CNA #1 as intentional abuse of the resident. Continued interview confirmed CNA #2 did not report the allegations to the CNA's immediate supervisor or administrative staff. C/O #29191	F 225	Social Services/ED/DON or designee will perform interviews with both residents and associates to ensure that any/all allegations/suspicions of abuse/neglect are reported immediately to the administrator or designee. Six residents and Six associates will be interviewed per week X12 weeks to ensure 100% compliance. SSD/ED will report findings to the Performance Improvement (PI) committee for 3 months for recommendations and follow-up. The PI committee includes the ED, DON, Medical Director, SSD, Consultant Pharmacist, and interdisciplinary Department Heads.	3/17/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	3/17/12

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F 281	Continued From page 4 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records and interview, the facility failed to follow physician's orders for laboratory studies for one (#4) of twelve residents reviewed. The findings included: Resident #4 was admitted to the facility on October 7, 2011, with diagnoses including Anorexia, Anxiety, Deep Vein Thrombosis in the left leg, End-Stage Renal Cancer, Hypertension, Anemia, Gastric Ulcer, Failure to Thrive, Diverticulosis, Chronic Diarrhea, History of Breast Cancer, History of Bilateral Mastectomy, Renal Stent placement and partial Gastrectomy for a Perforated Ulcer. Review of a hospital discharge summary dated October 7, 2011, revealed the resident was admitted to the hospital with Failure to Thrive and abdominal pain which began after stenting of the right renal system for obstruction due to Renal Cancer. Continued review revealed the resident was placed on Lovenox (blood thinner) injections daily due to the development of Deep Vein Thrombosis in the left leg. Medical record review of the Minimum Data Set (MDS) dated October 14, 2011, revealed the resident had short and long-term memory problems and moderately impaired	F 281	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** To address the situation involving the failure to obtain PT/INR results on resident #4, the facility took the following action. On 10/10/11, immediately after observing the labs were not obtained on resident #4, MD was notified and orders were obtained to do the PT/INR results. RN #1, who failed to transcribe the order for the PT/INR in the lab book, received a disciplinary action for failing to follow MD orders and was reeducated on the importance of obtaining labs as ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. Training, systemic changes, audits, and a performance improvement program as described below have been implemented to ensure that all other residents are provided with the appropriate services and that these services meet professional standards.	3/17/12

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F 281	Continued From page 5 decision-making skills and required maximum assistance with all activities of daily living. Medical record review of a physician's order dated October 7, 2011, revealed Lovenox 60 mg (milligrams) subcutaneous daily for six months and INR (International Normalized Ratio for monitoring blood thinner levels) daily starting October 8, 2011. Medical record review of a nurse's note dated October 12, 2011, revealed, "Order for INR verification daily on admission 10/07/11. INR not checked until 10/10/11." Medical record review of the "PT (Prothrombin Time)/INR/Coumadin Flow Sheet" revealed the desired range for the INR for Deep Vein Thrombosis was 2.0-3.0. Continued review revealed the INR results dated October 10, 2011, was 3.9, and an order to hold the Lovenox was given by the physician. Continued review revealed the INR results dated October 11, 2011, was 4.5, and an order to hold the Lovenox was again given by the physician. Continued review revealed the INR results dated October 12, 2011, was 4.2, and Lovenox 60 mg daily was ordered by the physician. Medical record review and interview in the conference room on January 24, 2012, at 2:00 p.m., with the Registered Nurse (RN #1) for 3:00 p.m.-11:00 p.m., shift on the unit where the resident resided, confirmed RN #1 failed to transcribe the order dated October 7, 2011, for the daily INR and confirmed the physician's order for daily INR was not followed. Continued interview confirmed the INR was not obtained on	F 281	**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 10/28/11 DON inserviced all licensed nurses to accurately transcribe and obtain all labs as ordered, including obtaining PT/INR when ordered, antibiotic and Coumadin interactions, and to obtain a PT/INR every three days while on antibiotics and one week after completion of antibiotic therapy as well as with any reason for concern such as interaction or abnormalities. **How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place?** DON/ADON will perform audits of all lab orders to ensure they are transcribed correctly in the lab book and are obtained on the appropriate date. These lab audits began on 10/18/11 and are being done weekly X16 weeks or until 100% compliance is achieved. DON/ADON will report findings to the PI committee for recommendations and follow up. This began at the end of October 2011 and will continue through February 2012. The Performance Improvement Committee	3/17/12

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F 281	Continued From page 6 October 8 and 9, 2011, as ordered. Interview on January 24, 2012, at 3:20 p.m., in the conference room, with the Nurse Practitioner (NP) revealed the INRs which were not obtained on October 8 and 9, 2011, did not result in harm to the resident, and the Lovenox was restarted by the physician when the INR was still elevated at 4.2 on October 12, 2011. C/O #28853	F 281	includes the ED, DON, Medical Director, Consultant Pharmacist, and interdisciplinary department heads.	3/17/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425	**F425 PHARMACEUTICAL SVC—ACCURATE PROCEDURES, RPH** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** To address the situation involving the failure to ensure a system was followed to account for the receipt and disposition of a controlled medication for the resident affected the facility took the following action. Immediately upon discovery of this all nurses that worked this cart between 9/22/11 and 10/19/11 (the period between which we signed for delivery and when we recognized the medication was missing) were interviewed to determine both if they counted and if they knew anything about the missing Lorazepam. All of these nurses admitted to not counting and also to not knowing anything about any missing medication. These nurses received disciplinary actions for failure to account	3/17/12

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F 425	Continued From page 7 Based on medical record review, review of pharmacy dispensing records, review of a letter to the physician, review of the facility investigation, facility policy review and interview, the facility failed to ensure a system was followed to account for the receipt and disposition of a controlled medication for one (#7) of twelve residents reviewed. The findings included: Resident #7 was admitted to the facility on November 5, 2008, with diagnoses including Glaucoma, Osteoarthritis of the knee, Cerebral Vascular Accident (Stroke) with Right Hemiparesis, Gastrointestinal Reflux Disease, Aphasia, Hypertension, Osteoporosis, Constipation and Vitamin B12 Deficiency. Medical record review of the Minimum Data Set dated December 8, 2011, revealed the resident scored 14 of 15 on the Brief Interview for Mental Status (BIMS) and had no cognitive impairment. Continued review revealed the resident had physical and verbal behavioral symptoms towards self and others and resisted care. Medical record review of a physician's order dated September 21, 2011, revealed Ativan (anti-Anxiety medication) 0.5 mg (milligrams) was ordered every six hours as needed for Anxiety. Review of the pharmacy dispensing record dated September 22, 2011, revealed fifteen(15) vials of Lorazepam 2 mg/(per) 1 ml (milliliter) was delivered to the facility on September 23, 2011, at 12:26 a.m., and Licensed Practical Nurse (LPN #1) signed the receipt for the fifteen vials.	F 425	for refrigerated narcotics and were inserviced on 10/28/11 and 11/3/11 regarding Medication Administration and Narcotics policies. The nurse that initially signed that she received the medication from the pharmacy was drug screened with a negative result. We notified the physician and replaced the missing medication at facility expense. We also interviewed alert and oriented residents throughout the facility to determine if they had encountered any issues with receiving their medications. None of the residents interviewed had any issues. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. Training, systemic changes, audits, and a performance improvement program as described below have been implemented to ensure that system is followed to account for the receipt and disposition of controlled medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 10/28/11 DON inserviced all licensed nurses on our Medication Administration and Narcotics policies. Additionally RN	3/17/12

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F 425	Continued From page 8 Review of a letter to the physician dated October 27, 2011, by the Director of Nursing (DON) revealed, "Dr. (name)...We have discovered a drug discrepancy on one of your patients. (Resident #7) was ordered Ativan 0.25 ml (0.5 mg) IM (intramuscular) every 6 hours PRN (as needed) for anxiety by the psyche (psychiatric) nurse on 09/21/11. The medication was received from pharmacy on 09/22/11. An LPN (Licensed Practical Nurse) signed accepting the medication and placed it in the refrigerated narcotics lock box...On 10/19/11, it was observed by a nurse during the narcotic count that there were only eleven 1 ml vials in the bag and the requisition sheet showed that there was supposed to be fifteen vials. The medication has not been given by anyone according to the MAR (Medication Administration Record) and the patient controlled substance record. I have completed an investigation and we are unable to determine what happened to the vials...Pharmacy was notified to determine if there may have been a discrepancy in the initial count when we had received it; since the LPN accepted the medication and admitted she did not count it to ensure it was accurate. Pharmacy records indicate fifteen vials were delivered. I interviewed all the nurses that work that cart and that are responsible for counting the refrigerated narcotics and they all admitted that they had not counted them after every shift to ensure an accurate count. Disciplinary actions will be given to all the nurses involved and two nurses are now required to count and sign for the delivery of all narcotics. Also, an inservice is scheduled for 10/28/11 to educate all nurses on proper procedure for controlled substances...After speaking with the	F 425	supervisors began auditing Narcotic count records on 11/5/11 to ensure all nurses have counted the narcotics and signed the record. Audits of the pharmacy requisitions are also being conducted. **How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place?** RN supervisors are auditing 100% of the Narcotic Count Records at the end of each shift to ensure that all nurses have counted the narcotics and signed the record. These audits began in November 2011 and will continue through February 2012 or until 100% compliance is achieved. DON/ADON is auditing the narcotic pharmacy requisitions each morning, or on Monday from the weekend to ensure that two nurses counted and signed for the medications per policy. This began in late October 2011 and will continue through February 2012 or until 100% compliance is achieved. DON/ADON will report findings to the PI committee for recommendations and follow up. This began at the end of October 2011 and will continue through February 2012. The Performance Improvement Committee includes the ED, DON, Medical Director,	3/17/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9 pharmacist and corporate, we as a facility will have to replace those vials at our expense. I am asking you for a prescription for (resident)...with a quantity of four (4) 1 ml vials. I would appreciate your cooperation in this manner. If you wish to call that in to the pharmacy the number is...Thank you for your support..." Review of the facility investigation revealed nurses were inserviced on October 28, 2011, of the facility's policy for controlled medications. Continued review of the investigation revealed thirteen nurses received disciplinary actions for failure to count the Ativan vials on receipt of the medication from the pharmacy and/or failure to count the medication at the end of each shift. Review of the facility's policy for controlled medications dated February 2009 revealed, "...Strict control of narcotics is always maintained...Appropriate storage, recording, and use of controlled drugs are always maintained on all units...Two nurses need to sign a receipt when receiving controlled drugs with a "proof of use sheet"...All controlled medications are kept under double-lock and in a separate drawer from other medications...When controlled keys change hands during a shift, controlled drugs are recounted and both nurses sign the "Change of Shift Count Record"...The actual controlled drugs are counted...If the count is incorrect, notify the supervisor and pharmacist..." Interview on January 24, 2012, at 3:30 p.m., in the conference room, with Registered Nurse (RN) #1 and LPN #2 confirmed RN #1 and LPN #2 failed to count the number of vials of Ativan for resident #7, in the locked refrigerator on unit two,	F 425	Consultant Pharmacist, and interdisciplinary department heads.	3/17/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	C 02/01/2012

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LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

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F 425	Continued From page 10 from September 23, 2011, to October 19, 2011. Both RN #1 and LPN #2 stated they were "aware" of errors from the pharmacy when the number of medications listed on the delivery manifest did not match the actual number of medications delivered. Interview on January 24, 2012, at 3:40 p.m., in the conference room, with RN #3 and LPN #1 confirmed RN #3 and LPN #1 failed to count the number of vials of Ativan for resident #7, in the locked refrigerator on unit two, from September 23, 2011, to October 19, 2011. Both RN #3 and LPN #1 stated they were "aware" of errors from the pharmacy when the number of medications listed on the delivery manifest did not match the actual number of medications delivered. Interview on January 25, 2012, at 8:50 a.m., in the conference room, with the DON confirmed LPN #1 failed to count the number of vials of Ativan delivered by the pharmacy on September 23, 2011, at 12:26 a.m., and confirmed nurses failed to count the number of vials of Ativan in the refrigerator from September 23, 2011, until October 19, 2011, at which time it was discovered the four vials were missing. Review of a pharmacy dispensing record and interview on January 25, 2012, at 8:50 a.m., with the DON revealed a pharmacy delivery record dated October 27, 2011, showed 4 vials of Ativan was delivered to the facility on October 27, 2011; however RN #1 checked the delivery record against the actual number of vials received, and the pharmacy had only delivered two vials instead of four. Interview with the DON during review of	F 425		

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F 425	Continued From page 11 the delivery record confirmed the delivery record from the pharmacy dated October 27, 2011, was inaccurate. Review of a pharmacy dispensing record and interview on January 25, 2012, at 8:50 a.m., with the DON revealed a pharmacy delivery record dated October 31, 2011, showed one emergency narcotic box was delivered to the facility on October 31, 2011; however LPN #1 checked the delivery record and the pharmacy had not delivered the emergency narcotic box as indicated on the delivery record. Interview with the DON during review of the delivery record confirmed the delivery record from the pharmacy dated October 31, 2011, was inaccurate, and an emergency narcotic box was not delivered. Continued interview with the DON confirmed the facility had encountered similar problems with the pharmacy in which the delivery records did not match what was actually received by the facility. C/O #28908	F 425		